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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **David Lawrence Kosh, M.D.** **8110 Timberlake Way** **Sacramento, CA 95823** **Physician's and Surgeon's Certificate No. G 40670,** Respondent.	Case No. 800-2017-036156 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 24, 1979, the Medical Board issued Physician's and Surgeon's Certificate Number G 40670 to David Lawrence Kosh, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides in pertinent part, that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. At all times alleged herein, Section 3502.1[1] of the Code provided that physician assistants issuing drug orders for scheduled medications were doing so on behalf of, and as an agent of, the supervising physician.

7. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Business and Professions Code section 725 provides that acts of clearly excessive prescribing of drugs is unprofessional conduct (subd. (a)) and a misdemeanor punishable by fine and incarceration (subd. (b)).

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence in the manner in which he provided opioid treatment to a patient with chronic nonmalignant pain. The circumstances are as follows:

[1] Business and Professions Code section 3502.1 was amended by Stats. 2018, Ch. 693, Sec. 10. Effective January 1, 2019.

11. A Confidential Patient (C.P.)[2], died on October 14, 2013 from an overdose of fentanyl. Post-mortem toxicology showed the presence of fentanyl, norfentanyl, amphetamine, methamphetamine, clonazepam, alprazolam, and THC. C.P. was 36 years old at the time of his death. The Coroner's report described C.P.'s teeth as carious, with many of them presenting as totted stubs along the gumline.

12. Respondent is a Board-certified Family Medicine physician at Associated Family Physicians, in Sacramento, California. On or about April 17, 2012, C.P. initiated care at Associated Family Physicians. C.P. was initially seen by a Nurse Practitioner in the practice. C.P. reported having a fever and a rash, with a history of MRSA infection. He reported having pseudoseizures lasting seconds with associated amnesia. He reported that he had been evaluated by multiple neurologists. The Nurse Practitioner noted that C.P. had a history of methamphetamine abuse, as well as carpal tunnel syndrome, peptic ulcer disease, lumbar disc herniation with myelopathy, sciatica, medical marijuana use, testicular hypofunction, migraine headaches, pseudo-seizures, panic disorder, and tobacco use. At his initial visit with the Nurse Practitioner, C.P. reported that he discontinued opioid pain medication about four weeks before this visit. He reported a taper of morphine and discontinuation of Norco and oxycodone. His medications were listed as Androgel, albuterol, dicyclomine, Klonopin, 2mg (frequency not specified), Lasix 20-40 mg as needed for edema, Phenergan 12.5-25 mg as needed for nausea, Zofran, and medical marijuana by vaporizer. An MRI of C.P.'s brain was noted to show demyelination and gliosis as of November 10, 2011. An MRI of the lumbar spine on July 9, 2009 showed left paracentral disc extrusion and post-operative findings consistent with hemi laminectomy.

13. At the April 17, 2012 appointment, C.P.'s temperature was 100.4 degrees Fahrenheit. The physical examination revealed poor hygiene, anxiety, a popular erythematous rash on the neck and arms, a nonfocal neurological examination, and a normal psychiatric examination. The assessment listed MRSA cellulitis, pseudoseizure, and testicular hypofunction. The plan was a

[2] To protect the patient's identity, his name is withheld from this Accusation. His identity will be included in the discovery materials provided to Respondent.

referral to an endocrinologist, Bactrim DS twice per day, Norco 10/325 1-2 tablets every 4 to 6 hours as needed for pain. C.P.'s medications were listed as Oxycodone 10 mg every 4 hours, Phenergan 25 mg three times per day as needed for nausea, buspirone 5 mg twice per day, Xanax 2 mg twice per day as needed, and Klonopin half a tablet every 6 hours. The quantities of Phenergan and controlled medications were not noted.[3] The CURES data and Pharmacy records do not show that the Nurse Practitioner prescribed these, or any, controlled medications to C.P. The CURES reports do show that C.P. continued to fill prescriptions for morphine and Norco from his previous provider, even several weeks after he initiated care at Associated Family Physicians.

14. C.P.'s records from Associated Family Physicians show that on or about April 19, 2012, he called to request a refill of oxycodone, claiming that he had taken his last oxycodone pill that morning, (contrary to his claim to the Nurse Practitioner that he had stopped all opioid medication thirty days before that appointment). It is not clear if Phenergan was prescribed. On April 17, 2012, a telephone note indicated buspirone 5 mg twice per day.

15. Respondent saw C.P. for the first time on or about April 23, 2012. The chief complaint listed in the medical record of this visit is Medication Review. The history and medications were confirmed. Phenergan is listed at 12.5 mg twice per day as needed for nausea. Neither oxycodone nor Norco are listed as medications being taken. Xanax is listed at 2 mg, twice per day. C.P. did not have a fever. A physical examination was not documented. As his assessment, Respondent listed lumbar disc herniation with myelopathy. Respondent did not list any opioid medications in the treatment plan. During his interview with Board investigators, Respondent stated that there should be a report that he dictated for every patient visit he had with C.P. He could not explain why the dictated report was not in the record for any of his visits with C.P. C.P. filled a prescription for 10 fentanyl patches at 50 mcg/hour from Respondent on or about April 23, 2012.

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[3] Phenergan (Promethazine) is a first-generation antihistamine. It is indicated for the treatment of nausea and vomiting. It is not recommended for long term use. It causes respiratory and central nervous system suppression and potentiates the euphoric effect of opioid and benzodiazepine medication. It is often abused with opioids and has a high black market value.

16. At his interview with Board investigators, Respondent stated that he did not view C.P. to be at any greater risk than other patients for medication misuse due to having a history of methamphetamine abuse because C.P. stated that he stopped using methamphetamine. Respondent did not do any toxicology testing of C.P. to check for aberrant drug behaviors, either before beginning treatment or during the course of treatment. When asked by Board investigators why he did not do toxicology screening on C.P., Respondent stated that it was not his custom at the time to do so. There is no documentation in the record to show that Respondent discussed with C.P. the risk and benefits of the opioid medications and other controlled medications he prescribed to C.P. Respondent told Board investigators that it was not his practice to discuss the risks of respiratory danger from controlled medications in 2012.

17. A series of telephone messages show that between April 30, 2012 and May 1, 2012, C.P. called Associated Family Physicians to report that his pain patch was not strong enough, and to request additional opioid medications. A May 2, 2012 telephone note states that Norco was refilled. C.P. filled a prescription for Norco from Respondent on May 1, 2012. C.P. also filled a prescription for morphine sulfate from his previous provider on May 6, 2012.

18. On or about May 9, 2012, C.P. had another appointment with Respondent. At this appointment Respondent indicated that C.P. was doing better with his pain management with Duragesic[4] 50 mcg patch and using Norco 10 mg several times a day as needed for backup. Respondent recorded that C.P.'s function was improving although an examination was not documented. The assessment recorded incomplete control of pain, and the plan was to increase Duragesic to 75 mcg, and use Roxonal[5] rather than Norco. The frequency of the Duragesic was not specified. There are no instructions on how to take the Duragesic and Roxonal documented. Respondent did not specify what, if any, medications he was prescribing on this visit. CURES shows that C.P. filled a prescription for morphine sulfate and Fentanyl from Respondent on May 9, 2012, and a prescription for Norco from his previous provider on May 11, 2012.

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[4] Duragesic is the transdermal formulation of fentanyl.

[5] Roxonal, or morphine elixir, is a liquid formulation of morphine. The formulation C.P. used was 20 mg/ml. Roxonal is a potent, rapidly acting opioid used mainly in the outpatient setting to treat terminal cancer pain in a hospice setting. When held in the mouth sublingually, it passes metabolism by the liver and can provide a rapid high similar to that of heroin.

19. After the May 9, 2012 appointment with Respondent, C.P.'s medical records contain a series of telephone call notes. The first is a May 13, 2012 note indicating that Klonopin was being refilled. Next a May 16, 2012 note stated that C.P. was complaining of seizures. The note appears to show that Klonopin and Roxonal were refilled. A May 18, 2012 telephone note shows that Phenergan, buspirone, Lasix, and Nasonex and Xanax were refilled. Respondent recorded a note in the telephone encounter dated May 19, 2012, stating "pls inquire about this one. [Nurse Practitioner] wrote down 2 mg tabs tid when he was accepted as a new pt. what and how much is he really taking?" A medical secretary added a note that C.P. was using "Klonopin 4 tid" and Xanax as needed. In this note, Zofran is also listed, as well as Klonopin, and Roxonal. The next day, on or about May 20, 2012, Respondent wrote "pts self altered treatments with controlled medications makes me very concerned. I do not feel comfortable treating him with additional medications till he sees me in person at the scheduled appointment."

20. On or about May 24, 2012, C.P. had an appointment with Respondent. Respondent recorded that C.P. had problems with the Duragesic patch adhering to his skin. The plan was to use a bio-occlusive dressing over the patches. Respondent also recorded that C.P. explained his use of benzodiazepines to him. He stated he was taking Klonopin 2mg half a tablet every six hours, and he also uses an occasional 1 mg, when he feels a pseudo seizure coming on. It was not clear whether C.P. was claiming that he used an additional 1 mg of Klonopin or Xanax, since the Xanax dose recorded to date was 2 milligrams. During his interview with Board investigators, Respondent acknowledged that he never spoke with a psychiatrist about C.P.'s pseudoseizures to try to obtain advice or a consultation.

21. C.P. next saw a Physician Assistant in the practice, on or about May 25, 2012, for a fall and head injury. The Physician Assistant recorded that C.P. was using more Roxonal than prescribed and may need an early refill. The dose of Xanax is noted here to be 1 mg. C.P. is also noted to be taking Norco, Duragesic, Roxonal, and Promethazine. Promethazine is listed as both 12.5 and 25 mg.

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22. On or about May 31, 2012, C.P. called to request an early refill of Duragesic, which was approved by Respondent. On or about June 5, 2012, C.P called to request a refill of Xanax. Respondent entered a note in the telephone encounter stating, "need to know how many Xanax he takes per day." On or about June 14, 2012, another telephone note reflects that a refill for Klonopin was faxed and states "pt not happy with the Klonopin 1 mg." A telephone note on or about June 26, 2012 states "Pt called stating that since his Klonopin dose has changed he has been having multiple seizures a day. He stated it is delusional dementia."

23. On or about June 26, 2012, C.P. saw the Physician Assistant for an injury to his right wrist. On or about June 27, 2012, a telephone note indicates C.P. requested and obtained a refill of Phenergan. On or about July 1, 2012, C.P. called to request a refill of Duragesic and Xanax. The note does not indicate the strength of the refills.

24. On or about July 10, 2012, C.P. saw Respondent. Respondent recorded that the pseudoseizures were controlled with Klonopin 2mg twice per day, and therefore the use of Xanax has decreased. Respondent recorded that C.P.'s pain was well controlled with Duragesic and Roxonal. Norco was not discussed. The plan was to increase the Klonopin, and continue Duragesic and Roxanol, and decrease Xanax. On or about July 13, 2012, C.P. called to report having multiple falls. His medication list included Klonopin, 2 mg, Xanax 1 mg, and Phenergan 25 mg.

25. On or about July 26, 2012, C.P. had a visit with a Physician Assistant for an injury to his foot. In addition to Klonopin, Xanax, Duragesic and Roxonal, Norco is listed among his medications. Throughout the rest of July, 2012, C.P. made several telephone calls to request and obtain refills of Roxonal, Duragesic, and Xanax.

26. On or about August 11, 2012, C.P. called to report a possible shingles rash, and request additional pain medication before he could be seen in the office. Respondent noted that C.P. already has a lot of pain medication. On or about August 12, 2012, C.P. was seen by a Physician Assistant and diagnosed with and treated for shingles. There is a separate record indicating that Respondent saw C.P. for this visit. It is not clear which provider saw him on this date.

27. The medical records show that C.P. did not have any in-person appointments at Associated Family Physicians after the August 12, 2012 appointment through the rest of 2012. However, there are multiple telephone note encounters recorded. On or about August 24, 2012, a telephone call note reflects that C.P. called to request, and obtained a refill of Roxonal. On August 28, 2012, a note shows C.P. called to report a possible MRSA infection. A visit was recommended. Bactrim was called in for C.P. On August 29, 2012, C.P. called again to request refills and to request that the Xanax prescription change from the 1 milligram to the 2 milligram formulation for cost reasons. The strength of the refill is not listed in the encounter note.

28. Throughout September, October, and November, 2012, C.P. called in and received refills of Klonopin, Roxonal, Xanax, and Duragesic. On or about December 10, 2012, C.P. was arraigned in Sacramento Superior Court on a felony drug charge. On or about December 13, 2012, C.P. called and received a refill of 30 Xanax tablets. Roxonal and Klonopin were refilled on or about December 22, 2012. On or about December 21, 2012, a note indicates that C.P. was sent a discharge letter from the practice stating that he had failed to pay his bill. A December 24, 2012 note stated that the discharge letter was mailed November 19, 2012, and that he would receive acute care only due to having a balance owed. The note further indicates that C.P. would call back and make billing arrangements. On or about December 31, 2012, a telephone note shows that C.P.'s Xanax prescription was refilled with 60 tablets. From this point onward, CURES shows that C.P. received the Xanax 2 mg in the quantity of 60 tablets, which was double the amount of his previous dose. There is no corresponding record indicating the reason for this change.

29. On or about January 8, 2013, Respondent had another visit with C.P. At this appointment Respondent and C.P. discussed C.P.'s reports that the Duragesic patch he was using would not adhere, and Nasonex was recommended to assist with that. Respondent noted that C.P. reported visual hallucinations, and that "he would just like the hallucinations to go away." Respondent noted that C.P. was previously seen by a psychiatrist, but cannot find one who takes

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Medicare. Respondent ordered Zyprexa[6] 10 mg at bedtime, and to return in two weeks. No physical examination is documented. During his interview with Board Investigators, Respondent stated that he did not believe it would be possible to obtain a psychiatric referral for C.P. because in his experience patients with C.P.'s medical insurance would not be accepted as patients by psychiatrists in the Sacramento area.

30. On or about January 25, 2013, C.P. had another visit with Respondent. He reported his hallucinations were improved. He stated that he accidentally doubled his dose of Zyprexa and that helped his hallucinations. Respondent did not document a physical examination. Respondent did not specifically record the plan for use of Zyprexa going forward from this visit, although subsequent records reflect C.P.'s dose of Zyprexa continued to be the doubled amount of 20 mg. Throughout January, February, and March, telephone notes indicate that Xanax, Duragesic, and Roxonal were refilled.

31. On or about March 14, 2013, C.P. had an appointment with Respondent. At this visit, C.P.'s prolactin was noted to be minimally elevated. A workup of hyperprolactinemia was briefly discussed, but no physical examination is recorded.

32. On or about April 3, 2013, C.P. pled no contest to a felony drug crime, and was sentenced for the offense. On or about April 4, 2013, a telephone note in C.P.'s file shows that C.P.'s father dropped off a form to the Office to fill out relieving C.P. from having to participate in the Sheriff's Department work-release program. On or about April 5, 2013, C.P. had an appointment with Respondent to discuss the paperwork. The record of this appointment does not include a history of present illness, physical examination or any reports of C.P.'s mental status. Respondent executed a document entitled "Physician's Evaluation" from the Sacramento County Sheriff's Work Release Division. The form indicated that applicants for Work Release Program require a medical release from their physician, and that applicants for the Home Detention Program require a release from their physician, as well as a letter on the physician's letterhead.

[6] Zyprexa (olanzapine) is a second generation antipsychotic medication that is used in the treatment of bipolar disorder and schizophrenia, particularly schizophrenia associated with agitation. It can be used off label to treat acute intoxicated delirium resulting from amphetamine intoxication. It has additive CNS depressant effects with opioids, benzodiazepines, and muscle relaxers. It carries a black box warning for use in dementia-related psychosis.

Respondent filled out the form indicating that he saw C.P. on April 5, 2013, for chronic pain syndrome, and that C.P. takes medications including fentanyl and Klonopin, and that he was unable to perform any activities at all. Respondent further signed a letter on his letterhead stating that C.P. is able to participate in the Home Detention Program. This was the last in-person appointment C.P. had with Respondent.

33. On or about April 23, 2013, a telephone message notes that C.P. called to request a refill of Roxonal, and stating the pharmacist recommended he take the medication three times a day instead of twice to prevent him from getting sick. Respondent responded that the suggestion did not make clinical sense. On or about May 4, 2013, C.P. saw a different physician in the practice for foot pain and was given a podiatry referral. This was the last in-person visit C.P. had with Associated Family Physicians.

34. During May, June, July, August, and September, C.P. continued to receive refills of controlled medications from Respondent, despite not coming in for any appointments. Between May 23, 2013, and September 4, 2013, the telephone notes in C.P.'s chart show that he called to request and obtained refills on Roxonal, Duragesic, Xanax, and Klonopin. On or about August 23, 2013, Respondent prescribed 60 tablets of Klonopin 2 mg. On or about September 12, 2013, respondent prescribed an additional 180 tablets of Konopin 2mg. On or about September 12, 2013, Respondent prescribed 180 tablets of Xanax 2 mg, and then a separate, additional prescription of Xanax 2 mg tablets on or about September 19, 2013. This represents a quadrupling of the effective dose of Klonopin, and an increase in C.P.'s dose of Xanax by more than tenfold in the month before his death. C.P. died fifteen days after the final prescription of Xanax, with no Xanax detected in his system.

35. Respondent's medical records for C.P. do not contain any reason or explanation for the sudden marked increase in the amount of Xanax and Klonopin he prescribed to C.P. At his interview with Board investigators, Respondent suggested that this may have been an error.

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36. During his interview with Board investigators, Respondent stated that it was his usual practice to follow up with patients every six months for an appointment once the patient was stable on an opioid medication regimen. He stated it was not unusual for him to not see C.P. during the time leading up to C.P.'s death.

37. Respondent stated that he was unaware that C.P. was charged or convicted of a drug crime during his time as a patient with Associated Family Physicians. Respondent indicated that when filling out paperwork for a patient for a medical release with the Sheriff's Work Release Program it would be his normal practice to inquire as to the circumstances of the legal troubles. However, in this case, he claims not to have done so, even at the appointment that was scheduled for the purpose of completing this paperwork. Board investigators spoke with C.P.'s relatives after his death and they reported that they were aware of his legal troubles, and believed it was the result of C.P. attempting to sell prescription medications to an undercover police officer. They further reported that C.P. was known to put the fentanyl patches in his mouth to chew on them.

38. The medical record does not contain a clear statement of what quantity of each medication is prescribed at each specific date. However, a review of the pharmacy and CURES records show that C.P. filled the following prescriptions at these amounts on these dates, which correspond to the following daily dose of medication:[7]

Duragesic (Strength in mcg/Hr)

Date	Str.	#	Patch/day	Mcg/hr
4/23/12	50	10	0.6	62.5
5/9/12	75	10	0.4	62.5
6/2/12	75	15	0.5	77.6
7/1/12	75	15	0.5	75.0
7/31/12	75	15	0.5	77.6
8/29/12	75	15	0.5	72.6
9/29/12	75	15	0.5	80.4

Roxonal 20 mg/ml

Date	mL	mL/d
5/9/12	30	1.7
5/27/12	60	2.0
6/26/12	60	2.0
7/26/12	60	2.1
8/24/12	60	2.1
9/22/12	60	2.0
10/22/12	60	2.0

[7] Approximately four of these prescriptions were relayed by the Physician Assistant being supervised by Respondent. Because the Physician Assistant was acting as an agent for Respondent, seeing Respondent's patient, Respondent is responsible for the prescriptions.

(Cont.) Duragesic (Strength in mcg/Hr)

Date	Str.	#	Patch/day	Mcg/hr
10/27/12	75	15	0.5	72.6
12/26/12	75	15	1.2	173.1
1/8/13	100	15	0.5	96.8
2/8/13	100	15	0.5	107.1
3/8/13	100	15	0.5	107.1
4/5/13	100	15	0.3	50.0
6/4/13	100	15	0.5	107.1
7/2/13	100	15	0.5	96.8
8/2/13	100	15	0.4	85.7
9/6/13	100	15	0.5	100

Roxonal 20 mg/ml

Date	mL	mL/d
11/21/12	60	1.9
12/23/12	60	12.0
1/22/13	60	1.9
2/22/13	60	1.8
3/28/13	60	2.3
4/23/13	60	2.0
5/23/13	60	1.8
6/25/13	60	1.9
7/26/13	60	1.8
8/28/13	60	1.9

Klonopin

Date	Strength	#	mg/d
5/13/12	2	60	3.8
6/14/12	1	60	2.3
7/10/12	2	60	4.0
8/9/12	2	60	3.8
9/10/12	2	60	4.1
10/9/12	2	60	3.5
11/12/12	2	60	3.0
12/22/12	2	60	3.9
1/22/13	2	60	3.9
2/22/13	2	60	3.8
3/26/13	2	60	4.3
4/23/13	2	60	4.0
5/23/13	2	60	3.9

Xanax

Date	Strength	#	Mg/d
5/24/12	1	15	1.3
6/5/12	1	60	2.3
7/1/12	1	60	2.0
7/31/12	1	60	2.1
8/29/12	2	30	2.0
9/28/12	2	30	2.1
10/27/12	2	30	2.7
11/18/12	2	30	2.4
12/13/12	2	30	3.3
12/31/12	2	60	3.9
1/3/13	2	60	4.0
3/2/13	2	60	2.9
4/12/13	2	60	4.3

(Cont.) Klonopin

Date	Strength	#	mg/d
6/23/13	2	60	3.9
7/24/13	2	60	4.0
8/23/13	2	60	6.0
9/12/13	2	180	12.0

Xanax

Date	Strength	#	Mg/d
5/10/13	2	60	3.9
6/10/13	2	60	4.1
7/9/13	2	60	3.9
8/9/13	2	60	3.5
9/12/13	2	180	51.4
9/19/13	2	180	12.0

39. Respondent was grossly negligent in provision of opioid treatment to C.P. for his acts and omissions including, but not limited to, the following:

a. Failing to obtain and document informed consent to treat C.P. with opioid medications, particularly in light of his history of substance use disorder;

b. Failing to document and obtain informed consent for co-administration of opioids and benzodiazepines;

c. Failing to obtain a toxicology screening before initiating opioid medication for chronic pain;

d. Failing to document ongoing prescription from C.P.'s previous provider and other providers.

e. Failure to investigate C.P.'s prior and current opioid prescriptions by pharmacy checks, CURES review, or consultation with previous physicians before beginning to prescribe opioids to C.P.

f. Failure to maintain a high index of suspicion of aberrant drug behavior by C.P., and failure to make efforts to detect and address it;

g. Failure to recognize signs of aberrant drug behavior by C.P.;

h. Failure to respond to information concerning C.P.'s criminal arrest and conviction insofar as the criminal conduct could provide evidence of aberrant drug behavior.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

40. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he was repeatedly negligent in his provision of opioid treatment to C.P.

41. Paragraphs 10 through 38 are incorporated by reference as if fully set forth herein.

42. Respondent was repeatedly negligent for his act and omissions including but not limited to the following:

a. Failing to obtain and document informed consent to treat C.P. with opioid medications, particularly in light of his history of substance use disorder;

b. Failing to document and obtain informed consent for co-administration of opioids and benzodiazepines;

c. Failing to obtain a toxicology screening before initiating opioid medication for chronic pain;

d. Failing to document ongoing prescription from C.P.'s previous provider and other providers.

e. Failure to investigate C.P.'s prior and current opioid prescriptions by pharmacy checks, CURES review, or consultation with previous physicians before beginning to prescribe opioids to C.P.

f. Failure to maintain a high index of suspicion of aberrant drug behavior by C.P., and failure to make efforts to detect and address it;

g. Failure to recognize signs of aberrant drug behavior by C.P.;

h. Failure to respond to information concerning C.P.'s criminal arrest and conviction insofar as the criminal conduct could provide evidence of aberrant drug behavior; and

i. Failure to accurately and adequately document the types and amounts of controlled substances prescribed on each date.

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THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

43. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he was grossly negligent in his evaluation and management of C.P.'s psychiatric conditions.

44. Paragraphs 10 through 38, above, are incorporated herein as if fully set forth.

45. Respondent was grossly negligent for his acts and omissions including, but not limited to, the following:

a. failing to explicitly evaluate and document the potential for active methamphetamine use in C.P. despite the evidence he presented with at his initial visit including the history of methamphetamine use, current anxiety, poor hygiene, rotted teeth, and an infected rash on upper extremities;

b. failing to act on this evidence by obtaining a urine toxicology screening for drugs of abuse before beginning treatment of C.P.;

c. failing to vigorously pursue and document efforts to secure a neurological and psychiatric evaluation of C.P., a patient whom Respondent was treating with benzodiazepines for psychogenic nonepileptic seizures;

d. failing to institute and monitor rigorous anti-suicide precautions in C.P. from at least January 8, 2013 onward;

e. failing to perform frequent clinic visits with C.P. from at least January 8, 2013 onward given the absence of established psychiatric care;

f. continuing the simultaneous prescription of multiple toxic medications including opioids, benzodiazepines, and Phenergan from the January 8, 2013 visit onward;

g. failing to encourage C.P. to present to an Emergency Room with comprehensive psychiatric services instead of undertaking to treat C.P. with Zyprexa for psychosis without establishing a diagnosis to explain his psychotic symptoms;

h. failing to document consideration of somatic pain disorder as a diagnosis to explain some of C.P.'s chronic pain and to refer C.P. to either a pain treatment center or to a psychiatrist for treatment somatic pain disorder;

i. failing to recognize and respond to C.P.'s June 12, 2012 complaint of "delusional dementia" as an expression of symptoms of sever psychiatric disease requiring urgent efforts to refer him to psychiatric care, or to at least document efforts to do so;

j. continuing to prescribe Roxonal, Duragesic, Xanax, Klonopin, Phenergan, and Zyprexa after June 12, 2012, without obtaining toxicological screening to exclude the diagnosis of stimulant use disorder leading to intoxicated delirium;

k. prescribing massive and increased amounts of Klonopin, and Xanax in September of 2013; and

l. failing to recognize that he lacked the training and experience to treat C.P.'s complex and serious psychiatric disease from at least June 12, 2012 onward.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

46. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he was grossly negligent in his evaluation and management of C.P.'s psychiatric conditions.

47. Paragraphs 10 through 38, above, are incorporated herein as if fully set forth.

48. Respondent was repeatedly negligent for his acts and omissions including, but not limited to, the following:

a. failing to explicitly evaluate and document the potential for active methamphetamine use in C.P. despite the evidence he presented with at his initial visit including the history of methamphetamine use, current anxiety, poor hygiene, rotted teeth, and an infected rash on upper extremities;

b. failing to act on this evidence by obtaining a urine toxicology screening for drugs of abuse before beginning treatment of C.P.;

c. failing to vigorously pursue and document efforts to secure a neurological and psychiatric evaluation of C.P., a patient whom Respondent was treating with benzodiazepines for psychogenic nonepileptic seizures;

d. failing to institute and monitor rigorous anti-suicide precautions in C.P. from at least January 8, 2013 onward;

e. failing to perform frequent clinic visits with C.P. from at least January 8, 2013 onward given the absence of established psychiatric care;

f. continuing the simultaneous prescription of multiple toxic medications including opioids, benzodiazepines, and Phenergan from the January 8, 2013 visit onward;

g. failing to encourage C.P. to present to an Emergency Room with comprehensive psychiatric services instead of undertaking to treat C.P. with Zyprexa for psychosis without establishing a diagnosis to explain his psychotic symptoms;

h. failing to document consideration of somatic pain disorder as a diagnosis to explain some of C.P.'s chronic pain and to refer C.P. to either a pain treatment center or to a psychiatrist for treatment somatic pain disorder;

i. failing to recognize and respond to C.P.'s June 12, 2012 complaint of "delusional dementia" as an expression of symptoms of sever psychiatric disease requiring urgent efforts to refer him to psychiatric care, or to at least document efforts to do so;

j. continuing to prescribe Roxonal, Duragesic, Xanax, Klonopin, Phenergan, and Zyprexa after June 12, 2012, without obtaining toxicological screening to exclude the diagnosis of stimulant use disorder leading to intoxicated delirium;

k. prescribing massive and increased amounts of Klonopin, and Xanax in September of 2013; and

l. failing to recognize that he lacked the training and experience to treat C.P.'s complex and serious psychiatric disease from at least June 12, 2012 onward.

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FIFTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

49. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excessive amounts of controlled substances to C.P. causing him great harm.

50. Paragraphs 10 through 38 above, are incorporated herein as if fully set forth.

51. Respondent's conduct as described constitutes unprofessional conduct in violation of Business and Professions Code section 725 of the Medical Practices Act, and provides cause for discipline against his physician's and surgeon's certificate.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

52. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records of C.P.'s care and treatment.

53. Paragraphs 10 through 38, above, are incorporated herein as if fully set forth.

54. As set forth in paragraphs 10 through 38, above, Respondent failed to adequately and accurately document the provision of care to patient C.P., thus subjecting his license to discipline.

SEVENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

55. Respondent has subjected his license to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 10 through 38, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

56. To determine the degree of discipline, if any, to be imposed on Respondent David Lawrence Kosh, M.D., Complainant alleges that on or about December 6, 2013, in a prior disciplinary action entitled, "In the Matter of the First Amended Accusation Against David Lawrence Kosh, M.D." before the Medical Board of California, in Case No. 12-2010-206600,

Respondent was Publically Reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4). Under the terms of the Public Reprimand, Respondent was required to complete a Medical Recordkeeping course and a Clinical Training Program within 12 months. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 40670, issued to David Lawrence Kosh, M.D.;

2. Revoking, suspending or denying approval of David Lawrence Kosh, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering David Lawrence Kosh, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 11, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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